STATE OF MAINE

NURSING HOME ADMINISTRATORS LICENSING BOARD

APPLICATION FOR LICENSURE

- Residential Care Facility Administrator

Department of Professional and Financial Regulation
Office of Licensing and Registration
35 State House Station
Augusta, ME 04333-0035

Office Telephone: (207) 624-8626
Office Facsimile: (207) 624-8637
TTY/HEARING IMPAIRED: (888) 577-6690
Email: jennifer.l.mooney@maine.gov

Office located at: 122 Northern Avenue, Gardiner, Maine

Revised 2006

Application Guide for Licensure as a Residential Care Facility Administrator

Please read all the information carefully. If you have any questions, you can contact the Nursing Home Administrators Licensing Board office at (207) 624-8626 or email jennifer.l.mooney@maine.gov

Furnished to Applicant:

1. Application Guide for Licensure as a Residential Care Facility Administrator
2. Application for Licensure
3. Verification of Licensure Form
4. Authorization of Credit Card Payment Form

GENERAL INFORMATION:

All material pertaining to an application must be received by the Board within a span of no more than six months. Applications which remain incomplete for more than six months will be disposed of. Candidates whose applications have been incomplete for more than six months will be required to submit **new** application materials if they seek licensure.

All name and/or address changes must be submitted to the Board, **in writing**, either by mail or fax throughout your licensure.

All checks submitted to the Board should be made payable to the *Maine State Treasurer*

ELIGIBILITY FOR LICENSURE:

All applicants applying for a license as a **Residential Care Facility Administrator** must submit the following:

☐ Completed and signed application for licensure;

☐ **Fees:** All Checks/Money Orders should be made payable to the "Treasurer, State of Maine". If paying using a credit card please use the Credit Card form at the end of the application. All Fees can be in one payment;

- **$75.00** Application Fee
- **$200.00** License Fee
- **$15.00** Criminal History Records Check Fee

☐ Written documentation that the applicant meets the requirements for a Residential Care Facility Administrator as outlined in Chapter 3, § 1(B) of the Board Rules;

☐ Two (2) written character reference letters indicating that the applicant is of good record and reputation for honest and reliable conduct in personal and business affairs; and

☐ If applying by endorsement, Verification of Licensure from each state in which applicant holds or has held any certification, licensure, or other credential.

If you are applying for licensure by endorsement, you must meet the requirements of Chapter 6 of the Board Rules.

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OFFICE PHONE (207) 624-8626
TTY/HEARING IMPAIRED (888) 577-6690

Office Use Only			
License #			
Cash #			
Check #			
4290	1424	$200	RCA
4290	1446	$75	
4290	2619	$15	

JOHN ELIAS BALDACCI
GOVERNOR

ANNE L. HEAD
DIRECTOR

APPLICATION FOR LICENSURE AS A RESIDENTIAL CARE FACILITY ADMINISTRATOR

Notice regarding Social Security Number Disclosure

The following statement is made pursuant to the Privacy Act of 1974 section 7 (B). Disclosure of your social security number is mandatory. Solicitation of your social security number is solely for tax administration purposes pursuant to 36 MRSA section 175 as authorized by the Tax Reform Act of 1976 (42 USC section-405 (C) (2) (1)). Your social security number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your social security number and it shall be treated as confidential tax information pursuant to 36 MRSA section 191.

Notice regarding Public Information

This application is a public record for purposes of Maine's Freedom of Access Law, 1 MRSA §401, et seq. Public records must be made available to any person upon request. Information that you supply as part of this application (except your Social Security number) is public information. Other licensing records to which this information may later be transferred are also considered public records. Where permitted by law, your name, license number, mailing address and other information listed on this application may be posted on the State's website.

PLEASE TYPE OR PRINT THIS APPLICATION

☐ Residential Care Facility Administrator

Name: _____

Any other names used: _____

Social Security Number: _____ Date of Birth: _____

Mailing Address: _____ County: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: (_____) _____

Facility: _____

Mailing Address: _____ County: _____

City: _____ State: _____ Zip Code: _____

Work Telephone: (_____) _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Do you currently hold or have you previously held a license or registration in any jurisdiction?
   ☐ Yes ☐ No If yes, please complete the following:

   State: _____ License #: _____

   Date issued:_____ Expiration date: _____

2. Has your application for licensure been denied by any agency?
   ☐ Yes ☐ No If yes, please attach an explanation.

3. Has your license ever been suspended, revoked or subject to any disciplinary action by any state or jurisdiction? ☐ Yes ☐ No If yes, please attach an explanation

4. Have you pled quilty to, pled no contest to, or been found guilty of any crime? ☐ Yes ☐ No
   If yes, please attach a copy of the court document record for each crime and a statement of the circumstances surrounding that crime.

5. Have you ever been excluded from participation in Medicare/Medicaid reimbursement?
   ☐ Yes ☐ No If yes, please attach an explanation.

I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE ACCURATE AND REPRESENT A TRUE STATEMENT OF FACT. BY THE FACT OF THIS APPLICATION, I WAIVE OBJECTION AND AUTHORIZE THE BOARD TO MAKE SUCH INQUIRIES, AND HAVE ACCESS TO SUCH INFORMATION AS THE BOARD MAY CONSIDER NECESSARY TO DETERMINE GOOD CHARACTER AND SUITABILITY.

_____ _____

Signature of Applicant Date

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JOHN ELIAS BALDACCI
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VERIFICATION OF LICENSURE

The applicant listed below is applying for licensure in the State of Maine. The Maine Nursing Home Administrators Licensing Board requests written verification from each state the applicant holds or has held any certification, licensure, or other credential. This is your authority to release any information in your files, favorable or otherwise. **Please mail this verification directly to the Maine Nursing Home Administrators Licensing Board at the above listed address.**

The section below is to be completed by the applicant and forwarded to the State Board in which you hold or have held certification, licensure, or other credential. Any associated fees are the responsibility of the applicant. If Verification of Licensure is needed for more than one state, please copy form as needed.

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

License Number: _____ State: _____ Date of Issue: _____

_____ _____
Signature of Applicant Date

This section to be completed by the State Licensing Board where the applicant holds or has held any certification, licensure, or other credential.

Name: _____ Date of Birth: _____

Address: _____ Social Security #: _____

Home Telephone: (_____) _____ Work Telephone: (_____) _____

Education (mark the highest level) ☐ High School ☐ College

☐ Graduate ☐ Post Graduate

Type of License held: _____ License number: _____

State: _____ Date Issued: _____ Expiration Date: _____

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If this is not the state of original licensure, was license issued through reciprocity/endorsement?

☐ Yes ☐ No From what state? _____

Was this individual licensed on the basis of his/her certification through the American College of Health Care Administrators? ☐ Yes ☐ No

Status of License: ☐ Active ☐ Inactive ☐ Expired

Exam: ☐ NAB ☐ PES ☐ Other

Score Raw _____ Scale _____ Date of Exam: _____ State: _____

Was an AIT/Practicum successfully completed? ☐ Yes ☐ No

If yes, length of AIT/Practicum: _____

Has the Board ever disciplined the applicant? ☐ Yes ☐ No

If yes, please explain: _____

_____

Is there any investigation or disciplinary action pending? ☐ Yes ☐ No

If yes, please explain: _____

_____

Signed _____

Printed name and title _____

State Seal

State _____

Date _____

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Cash # _____
Check # _____
4290 1424 $200 RCA
4290 1446 $75
4290 2619 $15

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AUTHORIZATION OF CREDIT CARD PAYMENT

Fees owed to this Department may be paid by the use of a credit card. If you wish to pay your fee(s) with your credit card, please complete this form and send it with your application. Payment through credit cards will not be processed without this authorization form.

Name: **(applicant fees being paid for)**		
***Mailing Address*:** **(applicant fees being paid for)**		
City:	***State:***	***Zip Code:***
County:	***Telephone #: (_____)_____-_____***	

Name of cardholder: **(if other than applicant)**		
***Mailing Address*:** **(if other than applicant)**		
City:	***State:***	***Zip Code:***

I authorize the State of Maine, Department of Professional and Financial Regulation, Office of Licensing and Registration to charge my:

☐ **Visa** ☐ **MasterCard**_____
Card number

Expiration date: _____/_____/_____ in the amount of: $_____

Signature: _____Date: _____/_____/_____